Health Insurance

Aditya Birla Health Insurance Co. Limited



Activ Care Claim Form - Part B (To Be Filled In By The Hospital)

The issue of this Form is not to be taken as an admission of liability

Please include the original Preauthorization Request form in lieu of PART A (To be filled in block letters)

Name of the hospital: Name of the treating doctor:								
b. Hospital Id: c. Type of hospital: Network Non-network (if non-network fill Section E) d. Name of the treating doctor: e. Qualification: f. Registration No. with State Code: g. Phone No.: 2. DETAILS OF THE EXTENT ADMITTED a. Name of the Patient: b. IP Registration Number: c. Gender: Male Fernale d. Age: Years M. Months e. Date of Birth: Year Name of the Patient: b. Date of Discharge: Discharge: Discharge to home Discharge to another hospital Deceased i. If Maternity i) Date of Delivey: D. M. M. Y. Y. Y. Y. ii) Gravida Status: l. Status at Time of Discharge: Discharge to home Discharge to another hospital Deceased ii. Co-morbidities: iii. Co-morbidities: iii. Co-morbidities: iii. Co-morbidities: iii. Co-morbidities: iii. Co-morbidities: iii. If authorization obtained: Yes No b) Pre-authorization Number: c) If authorization obtained: Yes No ii. If Yes, give cause Self-inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption iii. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this; Yes No iii. If Medico legal: Ves No iv. Reported to Policie: Yes No v. Fili no.	1.	DETAILS OF HOSPITAL						
c. Type of hospital: Network Non-network (if non-network fill Section E) d. Name of the treating doctor: e. Qualification: f. Registration No. with State Code: g. Phone No.: 2. DETAILS OF THE PATIENT ADMITTED a. Name of the Patient: b. IP Registration Number: c. Gender: Male Female d. Age: Years M. Months e. Date of Birth: D. M. M. Y. Y. F. Date of Admission: D. M. Years M. Months b. Date of Discharge: D. M. M. Y. Y. F. Date of Admission: D. M. Y. Year M. Months c. Date of Discharge: D. M. M. Y. Y. J. Time: j. Type of Admission: Emergency Planned Day Care Maternity k. If Maternity i) Date of Delivery: D. M. M. Y. Y. Y. B. M. M. Y. Y. Y. B. Status at Time of Discharge: Discharge to home Discharge to another hospital Deceased m. Total Claimed Amount: Rs. 3. DETAILS OF AlLMENT DIAGNOSED (PRIMARY) a) ICD 10 Codes Description b) ICD 10 PCS Description j. Primary Diagnosis: ii. Additional Diagnosis: iii. Co-morbidities: iii. Co-morbidities: iii. Co-morbidities: iii. Procedure: a) Pre-authorization by network hospital not obtained, give reason: If authorization by network hospital not obtained, give reason: J. Hauthorization due to injury: Yes No i. If Yes, give cause Self-inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption iii. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police: Yes No v. FIR no.	a.	Name of the hospital:						
d. Name of the treating doctor: e. Qualification: f. Registration No. with State Code.: g. Phone No.: 2. DETAILS OF THE PATIENT ADMITTED a. Name of the Patient: b. If Registration Number: c. Gender: Male Femule d. Age: Y.Y. Years M. Months e. Date of Birth: D.M. M.Y.Y.Y. i. Time: j. Type of Admission: Femergency Planned Day Care Maternity k. If Maternity D Date of Delivery: D.M. M.Y.Y.Y. iii Gravida Status: l. Slatus at Time of Discharge: Discharge to home Discharge to another hospital Deceased m. Total Claimed Amount: Re. 3. DETAILS OF All MENT DIAGNOSED (PRIMARY) a) ICD 10 Codes Description b) ICD 10 PCS Description i. Primary Diagnosis: ii. Additional Diagnosis: iii. Co-morbidities: iiv. Co-morbidities: iii. Co-morbidities: iii. Co-morbidities: iii. The authorization obtained: Yes No b) Pre-authorization Number: c) If authorization by network hospital not obtained, give reason: d) Hospitalization due to injury: Yes No i. If Yes, give cause Scif-inflicted Road Traffie Accident Substance Abuse / Alcohol Consumption iii. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police: Yes No v. FIR no.	b.	Hospital Id:						
e. Qualification: f. Registration No. with State Code: g. Phone No.: 2. DETAILS OF THE PATIENT ADMITTED a. Name of the Patient: b. IP Registration Number: c. Gender: Male Female d. Age: Y Years Months c. Date of Birth: Maternity: Male Female d. Age: Y Years Months b. Date of Discharge: D. M. W. Y. Y. J. Time: b. Type of Admission: Emergency Planned Day Care Maternity k. If Maternity: Date of Delivery: D. M. W. Y. Y. Y. J. J. Time: b. Status at Time of Discharge: Discharge to home Discharge to another hospital Deceased m. Total Chaimed Amount: Rs. 3. DETAILS OF AILMENT DIAGNOSED (PRIMARY) a) ICD 10 Codes Description b) ICD 10 PCS Description i. Primary Diagnosis: ii. Additional Diagnosis: iii. Procedure 2: iii. Co-morbidities: iii. Procedure 3: iii. Co-morbidities: iii. Procedure 3: iii. Procedure 3: iii. Co-morbidities: iii. Procedure 3: iii	c.	Type of hospital: Network No	Type of hospital: Network Non-network (if non-network fill Section E)					
f. Registration No. with State Code.: g. Phone No.: 2. DETAILS OF THE PATIENT ADMITTED a. Name of the Patient: b. IP Registration Number: c. Gender: Male Female d. Age: Y Years M Months c. Date of Piirth: D. M. M. Y. Y. V. F. Date of Admission: D. M. M. Y. V. Y. g. Time: j. Type of Admission: Emergency Planned Day Care Maternity k. If Maternity i) Date of Delivery: D. M. M. Y. Y. Y. J.	d.	Name of the treating doctor:						
2. DETAILS OF THE PATIENT ADMITTED a. Name of the Patient: b. IP Registration Number: c. Gender: Male Female d. Age: Y Years Months e. Date of Birth: Male Female d. Age: Years Months e. Date of Birth: Male Female d. Age: Years Months e. Date of Discharge: Male Female d. Age: Years Months for time: j. Type of Admission: Emergency Planned Day Care Maternity k. If Maternity i) Date of Delivery: Male Yelly ii) Gravida Status: 1. Status at Time of Discharge: Discharge to home Discharge to another hospital Deceased m. Total Claimed Amount: Rs. 3. DETAILS OF ALLMENT DIAGNOSED (PRIMARY) 5. DETAILS OF ALLMENT DIAGNOSED (PRIMARY) i. Primary Diagnosis: ii. Additional Diagnosis: ii. Procedure 1: iii. Co-morbidities: iii. Co-morbidities: iii. Co-morbidities: iii. Procedure 3: iii. Co-morbidities: iii. Procedure 3: iii. Co-morbidities: iii. Thijury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police: Yes No v. FIR no.	e.	Qualification:						
a. Name of the Patient: b. IP Registration Number: c. Gender: Male Female d. Age: Y Y Years M Months e. Date of Birth: D M M Y Y Y Y I. Date of Admission: D M M Y Y Y Y g. Time: h. Date of Discharge: D M M Y Y Y Y i. Time: j. Type of Admission: Emergency Planned Day Care Matemity k. If Maternity i) Date of Delivery: D M M Y Y Y Y ii) Gravida Status: l. Status at Time of Discharge: Discharge to home Discharge to another hospital Deceased m. Total Claimed Amount: Rs. 3. DETAILS OF All MENT DIAGNOSED (PRIMARY) a) ICD 10 Codes Description b) ICD 10 PCS Description j. Primary Diagnosis: ii. Additional Diagnosis: iii. Co-morbidities: iii. Co-morbidities: iii. Co-morbidities: iii. Primary Diagnosis: iii. Procedure 2: iii. Co-morbidities: iii. Procedure 3: iii. Procedure 4: iii. Procedure 5: iii. Procedure 6: iii. Procedure 6: iii. Procedure 7: iii. Procedure 8: iii. Procedure 8: iii. Procedure 8: iii. Procedure 9: iii. Procedure 9: iii. Procedure 9: iii. Pr	f.	Registration No. with State Code.:						
a. Name of the Patient: b. IP Registration Number: c. Gender: Male Female d. Age: Y Y Years M Months e. Date of Birth: D M M Y V Y Y f. Date of Admission: D M M Y V Y Y g. Time: j. Type of Admission: Emergency Planned Day Care Maternity k. If Maternity i) Date of Delivery: D M M Y V Y Y ii) Gravida Status: 1. Status at Time of Discharge: Discharge to home Discharge to another hospital Deceased m. Total Claimed Amount: Rs. 3. DETAILS OF AILMENT DIAGNOSED (PRIMARY) a) ICD 10 Codes Description b) ICD 10 PCS Description i. Primary Diagnosis: ii. Additional Diagnosis: iii. Co-morbidities: iii. Co-morbidities: iii. Co-morbidities: iii. Procedure 2: iii. Co-morbidities: iii. Procedure 3: iiv. Co-morbidities: iii. Procedure 3: iiv. Co-morbidities: iii. Pre-authorization obtained: Yes No b) Pre-authorization Number: c) If authorization by network hospital not obtained, give reason: d) Hospitalization due to injury: Yes No i. If Yes, give cause Self-inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption ii. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police: Yes No v. FIR no.	g.	Phone No.:						
a. Name of the Patient: b. IP Registration Number: c. Gender: Male Female d. Age: Y Y Years M Months e. Date of Birth: D M M Y V Y Y f. Date of Admission: D M M Y V Y Y g. Time: j. Type of Admission: Emergency Planned Day Care Maternity k. If Maternity i) Date of Delivery: D M M Y V Y Y ii) Gravida Status: 1. Status at Time of Discharge: Discharge to home Discharge to another hospital Deceased m. Total Claimed Amount: Rs. 3. DETAILS OF AILMENT DIAGNOSED (PRIMARY) a) ICD 10 Codes Description b) ICD 10 PCS Description i. Primary Diagnosis: ii. Additional Diagnosis: iii. Co-morbidities: iii. Co-morbidities: iii. Co-morbidities: iii. Procedure 2: iii. Co-morbidities: iii. Procedure 3: iiv. Co-morbidities: iii. Procedure 3: iiv. Co-morbidities: iii. Pre-authorization obtained: Yes No b) Pre-authorization Number: c) If authorization by network hospital not obtained, give reason: d) Hospitalization due to injury: Yes No i. If Yes, give cause Self-inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption ii. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police: Yes No v. FIR no.								
b. IP Registration Number: c. Gender: Male Female d. Age: Y Years M Months e. Date of Birth: D M M V V V J f. Date of Admission: D M M V V V J g. Time: j. Type of Admission: Emergency Planned Day Care Maternity k. If Maternity i) Date of Delivery: D M M V V V J ii) Gravida Status: l. Status at Time of Discharge: Discharge to home Discharge to another hospital Deceased m. Total Claimed Amount: Rs. 3. DETAILS OF AILMENT DIAGNOSED (PRIMARY) a) ICD 10 Codes Description b) ICD 10 PCS Description i. Primary Diagnosis: ii. Additional Diagnosis: iii. Co-morbidities: iii. Co-morbidities: iii. Co-morbidities: iv. Co-morbidities: iv. Co-morbidities: iv. Co-morbidities: d) Hospitalization due to injury: Yes No i. If Yes, give cause Self-inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption ii. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police: Yes No v. FIR no.	2.	DETAILS OF THE PATIENT ADMITTER	D					
c. Gender: Male Female d. Age: Y Years M Months c. Date of Birth: D M M Y Y Y f. Date of Admission: D D M M Y Y Y g. Time: h. Date of Discharge: D M M Y Y Y j. i. Time: j. Type of Admission: Emergency Planned Day Care Maternity k. If Maternity i) Date of Delivery: D D M M Y Y Y Y ji) Gravida Status: l. Status at Time of Discharge: Discharge to home Discharge to another hospital Deceased m. Total Claimed Amount: Rs. 3. DETAILS OF AlLMENT DIAGNOSED (PRIMARY) a) ICD 10 Codes Description b) ICD 10 PCS Description i. Primary Diagnosis: ii. Additional Diagnosis: iii. Additional Diagnosis: iii. Co-morbidities: iii. Co-morbidities: iii. Procedure 2: iii. Co-morbidities: iii. Procedure 3: iiv. Co-morbidities: iii. Procedure: a) Pre-authorization obtained: Yes No b) Pre-authorization Number: c) If authorization by network hospital not obtained, give reason: d) Hospitalization due to injury: Yes No i. If Yes, give cause Self-inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption iii. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police: Yes No v. FIR no.	a.	Name of the Patient:						
e. Date of Birth: D M M Y Y Y f. Date of Admission: D D M M Y Y Y g. Time: h. Date of Discharge: D M M Y Y Y i. Time: j. Type of Admission: Emergency Planned Day Care Maternity k. If Maternity i) Date of Delivery: D M M Y Y Y ii) Gravida Status: l. Status at Time of Discharge: Discharge to home Discharge to another hospital Deceased m. Total Claimed Amount: Rs. 3. DETAILS OF AlLMENT DIAGNOSED (PRIMARY) a) ICD 10 Codes Description b) ICD 10 PCS Description i. Primary Diagnosis: ii. Additional Diagnosis: iii. Co-morbidities: iii. Co-morbidities: iii. Co-morbidities: iii. Procedure 2: iii. Co-morbidities: iii. Procedure: a) Pre-authorization obtained: Yes No b) Pre-authorization Number: c) If authorization by network hospital not obtained, give reason: d) Hospitalization due to injury: Yes No i. If Yes, give cause Self-inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption iii. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police: Yes No v. FIR no.	b.	IP Registration Number:						
h. Date of Discharge: D M M Y Y Y Y I. Time: j. Type of Admission: Emergency Planned Day Care Maternity k. If Maternity i) Date of Delivery: D M M Y Y Y II) Gravida Status: l. Status at Time of Discharge: Discharge to home Discharge to another hospital Deceased m. Total Claimed Amount: Rs. 3. DETAILS OF AILMENT DIAGNOSED (PRIMARY) a) ICD 10 Codes Description b) ICD 10 PCS Description i. Primary Diagnosis: ii. Additional Diagnosis: iii. Co-morbidities: iii. Co-morbidities: iii. Procedure 3: iv. Co-morbidities: iv. Details of Procedure: d) Pre-authorization obtained: Yes No b) Pre-authorization Number: c) If authorization by network hospital not obtained, give reason: d) Hospitalization due to injury: Yes No i. If Yes, give cause Self-inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption ii. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police: Yes No v. FIR no.	c.	Gender: Male Female	d.	Age: Y Y Years M	M Months			
j. Type of Admission: Emergency Planned Day Care Maternity k. If Maternity i) Date of Delivery: D. D. M. M. Y. Y. Y. W. ii) Gravida Status: 1. Status at Time of Discharge: Discharge to home Discharge to another hospital Deceased m. Total Claimed Amount: Rs. 3. DETAILS OF AILMENT DIAGNOSED (PRIMARY) 1. Primary Diagnosis: 1. Procedure 1: 1. Additional Diagnosis: 1. Procedure 2: 1. Iii. Co-morbidities: 1. Procedure 2: 1. Iii. Procedure 3: 1. V. Co-morbidities: 1. V. Co-morbidities: 1. If authorization obtained: Yes No b) Pre-authorization Number: 1. If authorization due to injury: Yes No 1. If Yes, give cause Self-inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption 1. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) 1. If Medico legal: Yes No iv. Reported to Police: Yes No v. FIR no.	e.	Date of Birth: D D M M Y Y Y Y	f. Date of Admission	ı: D D M M Y Y	Y Y g.	Time:		
k. If Maternity i) Date of Delivery: D D M N V V V ii) Gravida Status: 1. Status at Time of Discharge: Discharge to home Discharge to another hospital Deceased m. Total Claimed Amount: Rs. 3. DETAILS OF AILMENT DIAGNOSED (PRIMARY) a) ICD 10 Codes Description b) ICD 10 PCS Description i. Primary Diagnosis: ii. Additional Diagnosis: iii. Procedure 1: iii. Co-morbidities: iii. Procedure 2: iiii. Co-morbidities: iii. Procedure 3: iv. Co-morbidities: iv. Details of Procedure: a) Pre-authorization obtained: Yes No b) Pre-authorization Number: c) If authorization by network hospital not obtained, give reason: d) Hospitalization due to injury: Yes No i. If Yes, give cause Self-inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption ii. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police: Yes No v. FIR no.	h.	Date of Discharge: D D M M Y Y Y	y i. Time:					
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iv. Co-morbidities: iv. Details of Procedure: a) Pre-authorization obtained: Yes No b) Pre-authorization Number: c) If authorization by network hospital not obtained, give reason: d) Hospitalization due to injury: Yes No i. If Yes, give cause Self-inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption ii. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police: Yes No v. FIR no.	m.	Total Claimed Amount: Rs. DETAILS OF AILMENT DIAGNOSED (I a) ICD 10 Codes	PRIMARY)	b)		10 PCS I	Description	
a) Pre-authorization obtained: Yes No b) Pre-authorization Number: c) If authorization by network hospital not obtained, give reason: d) Hospitalization due to injury: Yes No i. If Yes, give cause Self-inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption ii. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police: Yes No v. FIR no.	m. 3.	Total Claimed Amount: Rs. DETAILS OF AILMENT DIAGNOSED (I a) ICD 10 Codes Primary Diagnosis:	PRIMARY)	b) i. Procedure 1:		10 PCS I	Description	
c) If authorization by network hospital not obtained, give reason: d) Hospitalization due to injury: Yes No i. If Yes, give cause Self-inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption ii. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police: Yes No v. FIR no.	m. 3. i. i ii.	Total Claimed Amount: Rs. DETAILS OF AILMENT DIAGNOSED (I a) ICD 10 Codes Primary Diagnosis: Additional Diagnosis:	PRIMARY)	b) i. Procedure 1: ii. Procedure 2:		10 PCS I	Description	
c) If authorization by network hospital not obtained, give reason: d) Hospitalization due to injury: Yes No i. If Yes, give cause Self-inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption ii. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police: Yes No v. FIR no.	m. i. : ii. : iii	Total Claimed Amount: Rs. DETAILS OF AILMENT DIAGNOSED (I a) ICD 10 Codes Primary Diagnosis: Additional Diagnosis: . Co-morbidities:	PRIMARY)	b) i. Procedure 1: ii. Procedure 2: iii. Procedure 3:	ICD	10 PCS I	Description	
d) Hospitalization due to injury: Yes No i. If Yes, give cause Self-inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption ii. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police: Yes No v. FIR no.	m. i. : ii. : iii	Total Claimed Amount: Rs. DETAILS OF AILMENT DIAGNOSED (I a) ICD 10 Codes Primary Diagnosis: Additional Diagnosis: . Co-morbidities:	PRIMARY)	b) i. Procedure 1: ii. Procedure 2: iii. Procedure 3:	ICD	10 PCS I	Description	
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i. If Yes, give cause Self-inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption ii. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police: Yes No v. FIR no.	i. i. iii iv.	Total Claimed Amount: Rs. DETAILS OF AILMENT DIAGNOSED (I a) ICD 10 Codes Primary Diagnosis: Additional Diagnosis: Co-morbidities: Co-morbidities: Pre-authorization obtained: Yes	PRIMARY) Description No b) Pre-	b) i. Procedure 1: ii. Procedure 2: iii. Procedure 3: iv. Details of Procedu	ICD	10 PCS I	Description	
ii. If injury due to Substance Abuse / Alcohol Consumption, test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No v. FIR no.	i. i. iii iv.	Total Claimed Amount: Rs. DETAILS OF AILMENT DIAGNOSED (I a) ICD 10 Codes Primary Diagnosis: Additional Diagnosis: Co-morbidities: Co-morbidities: Pre-authorization obtained: Yes	PRIMARY) Description No b) Pre-	b) i. Procedure 1: ii. Procedure 2: iii. Procedure 3: iv. Details of Procedu	ICD	10 PCS I	Description	
iii. If Medico legal: Yes No iv. Reported to Police: Yes No v. FIR no.	m. i. ii. iii. iv. a) c)	Total Claimed Amount: Rs. DETAILS OF AILMENT DIAGNOSED (I a) ICD 10 Codes Primary Diagnosis: Additional Diagnosis: Co-morbidities: Co-morbidities: Pre-authorization obtained: Yes If authorization by network hospital not obtain	PRIMARY) Description No b) Pre- ned, give reason:	b) i. Procedure 1: ii. Procedure 2: iii. Procedure 3: iv. Details of Procedu	ICD	10 PCS I	Description	
	m. i. ii. iii. iv. a) c)	Total Claimed Amount: Rs. DETAILS OF AILMENT DIAGNOSED (I a) ICD 10 Codes Primary Diagnosis: Additional Diagnosis: Co-morbidities: Co-morbidities: Pre-authorization obtained: Yes If authorization by network hospital not obtain Hospitalization due to injury: Yes	PRIMARY) Description No b) Presed, give reason:	i. Procedure 1: ii. Procedure 2: iii. Procedure 3: iv. Details of Procedure authorization Number:	ICD interest		Description	
iv. If not reported to police, give reason:	m. i. ii. iii. iv. a) c)	Total Claimed Amount: Rs. DETAILS OF AILMENT DIAGNOSED (I a) ICD 10 Codes Primary Diagnosis: Additional Diagnosis: Co-morbidities: Co-morbidities: Pre-authorization obtained: Yes If authorization by network hospital not obtain Hospitalization due to injury: Yes i. If Yes, give cause Self-inflicted	PRIMARY) Description No b) Presed, give reason: No Road Traffic Accide	i. Procedure 1: ii. Procedure 2: iii. Procedure 3: iv. Details of Procedurauthorization Number:	ICD acre:	ol Consumption		
	m. i. ii. iii. iv. a) c)	Total Claimed Amount: Rs. DETAILS OF AILMENT DIAGNOSED (I a) ICD 10 Codes Primary Diagnosis: Additional Diagnosis: Co-morbidities: Co-morbidities: Pre-authorization obtained: Yes If authorization by network hospital not obtain Hospitalization due to injury: Yes i. If Yes, give cause Self-inflicted ii. If injury due to Substance Abuse / Alcohological Alcohological Authorization of the company of the c	PRIMARY) Description No b) Presed, give reason: No Road Traffic Accided Consumption, test conduction	i. Procedure 1: ii. Procedure 2: iii. Procedure 3: iv. Details of Procedurauthorization Number:	re: ace Abuse / Alcoho	ol Consumption		
	m. i. ii. iii. iv. a) c)	Total Claimed Amount: Rs. DETAILS OF AILMENT DIAGNOSED (I a) ICD 10 Codes Primary Diagnosis: Additional Diagnosis: Co-morbidities: Co-morbidities: Pre-authorization obtained: Yes If authorization by network hospital not obtain Hospitalization due to injury: Yes i. If Yes, give cause Self-inflicted ii. If injury due to Substance Abuse / Alcoholiii. If Medico legal: Yes No	PRIMARY) Description No b) Presed, give reason: No Road Traffic Accided Consumption, test conductive. Reported to Police:	i. Procedure 1: ii. Procedure 2: iii. Procedure 3: iv. Details of Procedurauthorization Number:	re: ace Abuse / Alcoho	ol Consumption		
	m. i. i. iii iii iv. a) c)	Total Claimed Amount: Rs. DETAILS OF AILMENT DIAGNOSED (I a) ICD 10 Codes Primary Diagnosis: Additional Diagnosis: Co-morbidities: Co-morbidities: Pre-authorization obtained: Yes If authorization by network hospital not obtain Hospitalization due to injury: Yes i. If Yes, give cause Self-inflicted ii. If injury due to Substance Abuse / Alcoholiii. If Medico legal: Yes No	PRIMARY) Description No b) Presed, give reason: No Road Traffic Accided Consumption, test conductive. Reported to Police:	i. Procedure 1: ii. Procedure 2: iii. Procedure 3: iv. Details of Procedurauthorization Number:	re: ace Abuse / Alcoho	ol Consumption		

4. CLAIM DOCUMENTS SUBMITTED - CHECK	LIST:
a. Claim Form duly signed	b. Original Pre-authorization request
c. Copy of the Pre-authorization approval letter	d. Copy of Photo Id Card of patient verified by hospital
e. Hospital Discharge summary	f. Operation Theater notes
g. Hospital main bill	h. Hospital break-up bill
i. Investigation reports	j. CT/MR/USG/HPE investigation reports
k. Doctor's reference slip for investigation	1. ECG
m. Pharmacy bills	n. MLC reports & Police FIR
o. Original death summary from hospital where applicable	le
p. Any other PLEASE SPEC	I F Y
5. ADDITIONAL DETAILS IN CASE OF NON NE	TWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)
a. Address of the Hospital:	
-	
City:	State: Pin Code:
	Registration No. with State Code:
d. Hospital PAN:	e. Number of Inpatient beds:
f. Facilities available in the hospital: OT: Yes	No ICU: Yes No
g. Others:	
g. Culors.	
6. DECLARATION BY THE HOSPITAL (PLEASE	READ VERV CARFEILLIV
	is Claim Form is true & correct to the best of our knowledge and belief. If we have made any
•	of any material fact, our right to claim under this claim shall be forfeited.
, , , , , , , , , , , , , , , , , , ,	
Date: DDMMYYYY	
Place:	Signature and Seal of the Hospital
	Signature and Sear of the Hospital
Authority:	

GUIDANCE FOR	FILLING CLAIM FORM - PART B (To be filled	l in by the hospital)	
DATA ELEMENT	DESCRIPTION	FORMAT	
	SECTION A - DETAILS OF HOSPITAL		
a) Name of Hospital	Enter the name of hospital	Name of hospital in full	
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA	
c) Type of Hospital	Indicate whether In network or non network	Tick the right option	
	hospital		
d) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full	
e) Qualification	Enter the qualification of the treating doctor	Abbreviations of educational qualifications	
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India	
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number	
SEC	CTION B - DETAILS OF THE PATIENT ADMIT	TED	
a) Name of Patient	Enter the name of hospital	Name of hospital in full	
b) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider	
c) Gender	Indicate Gender of the patient	Tick Male or Female	
d) Age	Enter age of the patient	Number of years and months	
e) Date of Birth	Enter date of birth of the patient	Use dd-mm-yy format	
f) Date of Admission	Enter date of admission	Use dd-mm-yy format	
g) Time	Enter time of admission	Use hh:mm format	
h) Date of Discharge	Enter date of discharge	Use dd-mm-yy format	
i) Time	Enter time of discharge	Use hh:mm format	
j) Type of Admission	Indicate type of admission of patient	Tick the right option	
k) If Maternity			
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format	
Gravida Status	Enter Gravida status if maternity	Use standard format	
1) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option	
m) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)	
SECTIO	N C - DETAILS OF AILMENT DIAGNOSED (PI	RIMARY)	
a) ICD 10 Code			
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text	
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text	
Co-morbidities	Enter the ICD 10 Code and description of the co -morbidities	Standard Format and Open text	
b) ICD 10 PCS			
Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text	
Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text	
Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text	
Details of Procedure	Enter the details of the procedure	Open text	
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No	
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA	
e) If authorization by network hospital not	Enter pre-authorization number Enter reason for not obtaining pre-authorization	Open text	
obtained, give reason	number	-1	
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No	
Cause	Indicate cause of injury	Tick the right option	
If injury due to substance abuse/alcohol	Indicate whether test conducted	Tick Yes or No	
consumption, test conducted to establish this			
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No	
Reported To Police	Indicate whether police report was filed	Tick Yes or No	
	- •		

FIR No.	Enter first information report number	As issued by police authorities						
If not reported to police, give reason	Enter reason for not reporting to police	Open Text						
SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST								
Indicate which supporting documents are submitted								
SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL								
a) Address	Enter the full postal address	Include Street, City and Pin Code						
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number						
c) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India						
d) Hospital PAN	Enter the permanent account number	As allocated by the Income Tax department						
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits						
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify						
SECTION F - DECLARATION BY THE HOSPITAL								
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp								

Contact us: 1800 270 7000